PART D: MEDICAL RECORDS

1. *Medical Records*

The Army developed two training programs for medical records administrators. The purpose of the first training program is to educate administrators in the construction, storage, and care of medical records. The second program teaches medical records administrators the proper filing of forms and documents to create Army medical records, including the filing of authorization forms.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG022
TSP Title	Medical Records I
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for: MEDICAL RECORDS 1

This TSP Contains

TABLE OF CONTENTS

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0200	Prepare a DA Form 3444 or 8005 Series Folder
081-866-0201	Prepare a Temporary Medical Record
081-866-0202	Prepare an Ambulatory Procedure Visit (APV) Record

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	4.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	4.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements: There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
AR 40-2	Army Medical Treatment Facilities: General Administration (Reprinted w/Basic Incl C 1-2, 15 Mar 83) (03 Mar 78)	01 Jan 1900	
MCHO-CL-P (40)	MEDCOM Memorandum	16 Oct 1997	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
AR 40-3	Medical, Dental, and Veterinary Care (15 Feb 85)	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:

Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-56

Student Materials:

Student handout "Medical Records I Student Handout", M HPABG022 01.

Classroom, Training Area, and Range Requirements

CLASSROOM 44 PER, TABLES

Ammunition Requirements	**Name**		**Student Qty**	**Misc Qty**
	None			
Instructional Guidance	**NOTE:** Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material. The Instructor should distribute student handouts prior to the start of classroom presentation.			
Proponent Lesson Plan Approvals	**Name**	**Rank**	**Position**	**Date**

SECTION II. INTRODUCTION

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 4 hrs
Media: PRINT

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in a Medical Treatment Facility (MTF), but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 01: MEDICAL RECORDS I

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Define the purpose of medical records.
CONDITIONS:	Given AR 40-66
STANDARDS:	The soldier must define the purpose of medical records IAW AR 40-66.

1. Learning Step / Activity 1. Purpose of medical records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 02: Medical Records: Purpose

a. Provides a complete, concise medical and dental history for patient care.
b. Provides a source of patient information for Army programs.
   (1) Physical Evaluation Board.
   (2) MOS/Medical Retention Board.
   (3) Personnel Reliability Program.

Slide S HPABG022 03: Medical Records: Purpose

c. Provides a medico-legal support.
   (1) Legal rights of the patient.
   (2) Legal rights of the government.
d. Provides data for medical research and continuing education.

Slide S HPABG022 04: Medical Records: Purpose

e. Provides documentation for hospital accreditation.
   (1) Standards are set by the Joint Commission for Accreditation of Hospital Organizations (JCAHO).
   (2) Surveys and recommendations for improvement are made by JCAHO.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Status of medical record information.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 05: Medical Records: Status

a. "Private and confidential".
b. Used in diagnosis, treatment, and prevention of medical dental conditions.

c. Private; people not involved in a patient's care or in medical research shall not have access to a patient's medical records.
d. Legal documents; may be used as evidence in legal actions.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Coordination and responsibilities for medical records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 06: Medical Records: Coordination and Responsibilities

a. MTF and DENTAC commanders: official custodians of health records (HRECs) for members of units for which they provide primary medical and dental care.
b. Unit commanders: ensure that HRECs are always available to medical department personnel.

Slide S HPABG022 07: Medical Records: Coordination and Responsibilities

c. RC unit commanders: (receiving medical care from civilian sources) may act as custodians of their unit's HRECs only if no Army Medical Department (AMEDD) personnel are locally available.
d. Military personnel officers: ensures personnel changing station carry their HREC; where deemed inappropriate, forwards the HREC to the soldier's next station.

Slide S HPABG022 08: Medical Records: Coordination and Responsibilities

e. Patient Administration Chief: acts for the MTF/DENTAC commander in matters pertaining to medical records.
f. Health care providers: record all patient observations, treatments, and care, promptly and correctly.
(1) Must be clinically pertinent.
(2) Must be legible; should be typed, but may be handwritten. (Radiology, pathology, operative reports, and Narrative Summary Reports must be typed).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Select the appropriate type of record for different patient categories.
CONDITIONS:	Given AR 40-66 and AR 40-3
STANDARDS:	The soldier must select the type of record for category of patient for which it is prepared IAW AR 40-66 and AR 40-3.

1. Learning Step / Activity 1. Types of patient records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 10: Medical Records: Types

a. Health Record (HREC).
b. Outpatient Treatment Record (OTR).
c. Inpatient Treatment Record (ITR).
d. U.S. Field Medical Card (FMC).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Health Records (HREC)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 11: Medical Records: Health Records

a. Used in outpatient medical care.
b. Used in inpatient medical care.

Slide S HPABG022 12: Medical Records: Health Records

c. Categories of personnel for whom health records are prepared:
(1) Active duty personnel (Army, Navy, Marine, Air Force, Coast Guard)
(2) Reserve components (USAR/ARNG)
(3) Cadets of U.S. Military Academies
(4) Military prisoners while in confinement

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Outpatient Treatment Records (OTRs)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 13: Medical Records I: OTR

a. Used for each patient treated as an outpatient at a U.S. Army MTF and Dental Treatment Facility for whom a HREC is not prepared.
b. Categories for whom outpatient treatment records (OTRs) are prepared:

(1) Family members of active duty and retired personnel.
(2) Retired personnel.
(3) Civilian beneficiaries/civilian emergencies.

Slide S HPABG022 14: Medical Records I: OTR

c. Given to physicians, dentist, and other medical personnel attending an outpatient.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Inpatient Treatment Records (ITRs)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 15: Medical Records I: ITR

a. Used for each patient admitted at a U.S. Army MTF.
b. Categories for whom ITRs are prepared:
(1) All categories of patients.

Slide S HPABG022 16: Medical Records I: ITR

c. Given to physicians, dentist, and other medical personnel attending an inpatient.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. U.S. Field Medical Card (USFMC)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 17: Medical Records I: FMC

a. Used primarily in field or combat situations where health records are not available.
b. Used for all categories of combat personnel, not just active duty.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Prepare a DA Form 3444-Series Folder and DA Form 8005-Series Folder.
CONDITIONS:	Given AR 40-2, AR 40-66, DA Form 3444-Series Folder, DA Form 8005-Series

	Folder, colored tape, and DOD identification card
STANDARDS:	The soldier must prepare a DA Form 3444-Series and DA Form 8005-Series Folder IAW AR 40-2 and AR 40-66.

1. Learning Step / Activity 1. Selecting a folder color.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 18: Medical Records I: Series 3444-Series

Slide S HPABG022 19: Medical Records I: Series 8005-Series

Slide S HPABG022 20: Medical Records I: Folder Color

a. Determine the last two digits of the patient's SSN (the primary group).
b. Select the correct folder color (10 colors available) according to the patient's primary group (Table 1).

Slide S HPABG022 21: Medical Records I: Folder Color

Primary Group	Color	DA Form
00-09	Orange	3444 or 8005
10-19	Light green	3444-1 or 8005-1
20-29	Yellow	3444-2 or 8005-2
30-39	Gray	3444-3 or 8005-3
40-49	Tan	3444-4 or 8005-4
50-59	Light blue	3444-5 or 8005-5
60-69	White	3444-6 or 8005-6
70-79	Brown	3444-7 or 8005-7
80-89	Pink	3444-8 or 8005-8
91-99	Red	3444-9 or 8005-9

Folder Color
Table 1

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Labeling the patient's identification on the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 22: Medical Records I: Labeling

a. Put an identification label in the "Patient Identification" block of the folder.
(1) Use the patient's recording card.
(2) If the recording card is not available, type or print (blue or black ink) the patient's name, rank, grade, family member prefix, sponsor's SSN, patient's SSN, date of birth, the code for the MTF that maintains records, and register number.

Slide S HPABG022 23: Medical Records I: Labeling

b. For written entries on the folders, a fiber-tipped pen or other marking device should be used; do not use a pencil or regular pen.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Coding the Social Security Number and Family Member Prefix.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 24: Medical Records I: SSN

FMP	If the Patient Is the:
01	Sponsor's oldest child.
02	Sponsor's next oldest child.
03	Sponsor's third oldest child.
04, 05, and so on through 19	Sponsor's fourth oldest child through--
20	The SPONSOR
30 to 39 series	Sponsor's spouse or former spouse.
40	Sponsor's mother or stepmother.
45	Sponsor's father or stepmother.
50	Sponsor's mother-in-law.
55	Sponsor's father-in law.
60, 61, and so on through 69	Another relative.
90-95	Beneficiary assigned by statue.
98	Civilian brought to the MTF.
99	All others not elsewhere.

Assignment of FMP
Table 2

Slide S HPABG022 25: Medical Records I: SSN

a. Code the patient's SSN on the folder.

(1) Use 1 inch of black tape. Code the last digit of the SSN on the numbers on the right side and/or top of the folder by placing the tape over the number and wrapping it around the folder so that it covers the same number on the back of the folder. If tape is not available, the number may be blocked out with black ink.

Slide S HPABG022 26: Medical Records I: SSN

(2) Enter the last digit of the SSN in the far right block on the upper, top edge of the folder.

(3) Enter the two digits of the secondary group in the two empty blocks in the upper right corner to the left of the primary group numbers.
(4) Enter the remaining digits of the SSN in the five hyphenated blocks along the top of the folder.

Slide S HPABG022 27: Medical Records I: SSN

b. Enter the Family Member Prefix (FMP) number (Table 2) in the circles to the left of the tertiary numbers of the SSN.

FMP	If the Patient Is the:
01	Sponsor's oldest child.
02	Sponsor's next oldest child.
03	Sponsor's third oldest child.
04, 05, and so on through 19	Sponsor's fourth oldest child through--
20	The SPONSOR
30 to 39 series	Sponsor's spouse or former spouse.
40	Sponsor's mother or stepmother.
45	Sponsor's father or stepmother.
50	Sponsor's mother-in-law.
55	Sponsor's father-in law.
60, 61, and so on through 69	Another relative.
90-95	Beneficiary assigned by statue.
98	Civilian brought to the MTF.
99	All others not elsewhere.

Assignment of FMP
Table 2

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Code the folder's retirement date.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 28: Medical Records: Retirement Colors

YEAR RECORD IS TO BE RETIRED	TAPE COLOR
1995	Red
1996	Blue
1997	Green
1998	Yellow

1999	Silver or White
2000	Black
2001	Orange
2002	Red

Retirement Year Tape Colors
Table 3

Slide S HPABG022 29: Medical Records: Retirement Colors

a. On Inpatient Treatment Records (ITR) and Outpatient Treatment Records (OTR), to indicate the retirement year of the record, place a piece of 1/2" long tape, of the proper color IAW Table 2, over the letters "R" (retirement year) at the top of the folder and along the right edge of the folder.
b. Bend the tape over the edge of the folder so that it also covers the "R" on the backside.

NOTE: The letters are repeated on the top and edge of the folder to allow for different folder filing positions.

NOTE: The retirement date for OTRs will be 3 years after the end of the year in which the last medical treatment was given. ITRs will be retired after 5 years if a teaching hospital, and retired after 1 year if a non-teaching hospital. Health records are not retired.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Code the patient's "status".

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 30: Medical Records: Patient Status

RECORD TYPES COLOR	GENERAL GROUP
HRECs Red	Active duty military and RC personnel
DENTAL HRECs	on active duty or active duty training for more than 30 days.
Military ITRs Red	Military records (ITR)
Military Outpatient Records Green	Military other than active duty and RC
Military Dental Files	personnel on active duty or active duty training for less than 30 days.
Foreign and NATO ITRs Silver or	Foreign nationals and NATO

Foreign and NATO Dental Files
White

All others

Black

Tape Color Denoting Patient Status
Table 4

Slide S HPABG022 31: Medical Records: Patient Status

a. Show the status of the patient by putting a piece of 1/2" long tape, of the proper color IAW Table 3, over the letters "S" at the top of the folder and along the right edge of the folder.
b. Bend the tape over the edge of the folder so that it also covers the "S" on the backside.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Completing the remaining boxes and blocks on the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 32: Medical Records: Remaining boxes

a. Under the "Type of Record," check the proper box to show how the folder will be used.
b. Check the proper box under the "Note to Physician," if needed.
c. If known, enter the patient's blood type in the "Blood Type" blank.

Slide S HPABG022 33: Medical Records: Remaining boxes

NOTE: When the size of an individual medical record requires the creation of another folder, the folders will be labeled by volume numbers, e.g., "Vol. 1 of 2, Vol. 2 of 2". When one folder is removed from the file, all folders will be removed and kept together.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. The Privacy Act Statement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 34: Medical Records: Privacy Statement

a. Patient completes the "signature, sponsor's SSN, and date" blocks of the Privacy Act Statement (DD Form 2005) on the inside of the rear flap of the folder.
b. If the patient's DD 2005 is already completed, they do not need to complete a new one.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Prepare a Temporary Medical Record.
CONDITIONS:	Given AR 40-66, manila folder, and DOD identification card.
STANDARDS:	The soldier must prepare a Temporary Health Record IAW AR 40-66.

1. Learning Step / Activity 1. Prepare a temporary medical record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 35: Medical Records: Temporary Record

a. Use a manila folder rather than a DA Form 3444-series or DA Form 8005-series.
b. Initiate DD Form 2005 (Privacy Act Statement-Health Care Records).
c. File DD Form 2005 in the temporary record.
d. Print the patient's name on the folder.

Slide S HPABG022 36: Medical Records: Temporary Record

e. Print the patient's social security number on the folder.
f. Print the date the temporary record is initiated on the folder.
g. File documents on the person's medical condition as they are used.
h. File forms from the temporary treatment record into the applicable HREC, when it is received.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Prepare an Ambulatory Procedure Visit (APV) Record.
CONDITIONS:	Given DA Form 3444-Series Folder or a manila folder, MEDCOM Memorandum, MCHO-CL-C (40): Ambulatory Procedure Visit (APV)
STANDARDS:	The soldier must prepare an Ambulatory Procedure Visit (APV) Record IAW MEDCOM Memorandum, MCHO-CL-C (40): Ambulatory Procedure Visit (APV)

1. Learning Step / Activity 1. Definition of an Ambulatory Procedure Visit (APV).

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45

Media: PRINT

Slide S HPABG022 37: Medical Records: APV

a. The APV refers to a medical or surgical intervention requiring immediate (day of procedure), preprocedure, and immediate postprocedure care in an ambulatory procedure unit.
b. It is determined by the complexity, intensity, and duration of the care provided.

Slide S HPABG022 38: Medical Records: APV

c. A licensed or registered care practitioner will be directly involved in the health care intervention.
d. The total length of time that care is provided is less than 24 hours.

Slide S HPABG022 39: Medical Records: APV

NOTE: An Ambulatory Procedure Unit (APU) is one or more locations or freestanding outpatient clinics specially equipped, staffed, and designated for the purpose of providing the intensive level of outpatient care associated with APVs.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Complete the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 40: Medical Records: APV

a. Complete the standard forms (SF), or other forms recommended for use in the APV record:
(1) Privacy Act Statement (DD Form 2005).
(2) Abbreviated Medical Record (SF 539).

Slide S HPABG022 41: Medical Records: APV

(3) An ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to: preprocedure and postprocedure patient instructions, to include a brief physician summary of care provided, and Advanced Medical Directives.
(4) Provider Orders (DA Form 5256).

Slide S HPABG022 42: Medical Records: APV

(5) Other relevant forms, as appropriate:
a) Patient Procedure or Operative Consent (SF 522).
b) Operative Report (SF 516).
c) Tissue Report (SF 515).
d) Anesthesia Record (SF 517).

Slide S HPABG022 43: Medical Records: APV

(f) Progress Notes (SF 509), and all appropriate therapeutic documentation, to include postprocedure follow-up telephone call.

(g) Medical Record-Emergency Care and Treatment Record (SF 558), if any APV occurs subsequent to treatment in an Emergency Department/Service
(h) All diagnostic reports, e.g., laboratory, radiology, or electrocardiogram reports, etc.

Slide S HPABG022 44: Medical Records: APV

NOTE: Documentation for the APV record must meet the standards for a short-term stay (abbreviated medical record) and must comply with current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) documentation standards.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Route the forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 45: Medical Records: Route Forms

a. Forward a copy of the patient's postprocedure instructions with a summary of care (e.g., SF 509 or SF 539, etc.) to the Health/Outpatient Treatment Record (HREC/OTR).

NOTE: Ensure you annotate the APV on the DA Form 5571 (Master Problem List).

Slide S HPABG022 46: Medical Records: Route Forms

b. File all documentation related to the APV in a DA Form 3444-series folder, on the left side of the inpatient folder.

NOTE: Store APV records in a limited access area of the MTF, e.g., the inpatient records section.

Slide S HPABG022 47: Medical Records: Route Forms

NOTE: Do not integrate the original APV record into the HREC/OTR.

NOTE: Retire APV records to the National Personnel Records Center IAW AR 25-400-2, The Modern Army Record keeping System (MARKS).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

F. ENABLING LEARNING OBJECTIVE F

ACTION:	Prepare an Observation Record.
CONDITIONS:	Given a DA Form 3444-Series and Memorandum, MCHO-CL-P (40).
STANDARDS:	The soldier must prepare file forms for an Observation Record IAW Memorandum, MCHO-CL-P (40).

1. Learning Step / Activity 1. Definition of observation status.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 48: Medical Records: Observation Record

a. Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition.
b. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required.

Slide S HPABG022 49: Medical Records: Observation Record

c. Observation stays generally should not exceed 23 hours, but up to 48 hours may be authorized when medical necessity has been clearly indicated.
d. Criteria for patients in observation status:
(1) Written orders.
(2) Documentation addressing diagnosis or reason for placement.
(3) Orders for patient care and therapeutics.
(4) Determination of final disposition.

Slide S HPABG022 50: Medical Records: Observation Record

e. Observation status is appropriate for all types of patients for whom the physician and nursing care requirements necessitate monitoring for short durations.
f. Observation status should not be a substitute for medically appropriate inpatient care such as step-down units or critical care beds.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Complete the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 51: Medical Records: Observation Record

a. Complete the standard forms (SF), or other forms recommended for use in the Observation Record:
(1) Privacy Act Statement (DD Form 2005).
(2) Abbreviated Medical Record (SF 539).

Slide S HPABG022 52: Medical Records: Observation Record

(3) An ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to: preprocedure and postprocedure patient instructions, to include a brief physician summary of care provided, and Advanced Medical Directives.
(4) Provider Orders (DA Form 5256).

Slide S HPABG022 53: Medical Records: Observation Record

(5) Other relevant forms, as appropriate:
a) Patient Procedure or Operative Consent (SF 522).
b) Operative Report (SF 516).
c) Tissue Report (SF 515).
d) Anesthesia Record (SF 517).
(f) Progress Notes (SF 509), and all appropriate therapeutic documentation, to include postprocedure follow-up telephone call.

Slide S HPABG022 54: Medical Records: Observation Record

(g) Medical Record-Emergency Care and Treatment Record (SF 558).
(h) All diagnostic reports, e.g., laboratory, radiology, or electrocardiogram reports, etc.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Route the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 55: Medical Records: Observation Record

a. Forward a copy of the patient's postprocedure instructions with a summary of care (e.g., SF 509 or SF 539, etc.) to the Health/Outpatient Treatment Record (HREC/OTR).
b. File all documentation related to the Observation Record in a DA Form 3444-series folder, on the left side of the inpatient folder.

Slide S HPABG022 56: Medical Records: Observation Record

NOTE: Store Observation Records in a limited access area of the MTF, e.g., the inpatient records section.

NOTE: Do not integrate the original Observation Record into the HREC/OTR.

NOTE: Retire Observation Records to the National Personnel Records Center IAW AR 25-400-2, The Modern Army Record keeping System (MARKS).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson, you were introduced to the purpose of medical records in the Army medical community. We discussed some of their purposes: medical history, medico-legal support, and source of patient information. We learned certain patient categories and types of records. Also, you participated in practical exercises completing terminal digit file folders, temporary medical records, ambulatory procedure visits, and observation records.

Check on Learning

Conduct a check on learning and summarize the lesson:

QUESTION: What are four types of Army medical records?
ANSWER: Health Record, Outpatient Treatment Record, Inpatient Treatment Record, and U.S. Field Medical Card

QUESTION: Who is responsible for initiating the US Field Medical Card for a military member injured on the battlefield?
ANSWER: The aid or corpsman who first treats the injured patient.

QUESTION: Who is responsible for ensuring that HRECs are always available to Army medical department personnel?
ANSWER: Unit Commander.

QUESTION: What is the DA Form 3444-Series?
ANSWER: A file folder in which medical record forms may be stored and filed.

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records I". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PRACTICAL EXERCISE SHEET PE HPABG022 01

Title

Medical Records I - File Folder Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

During the discussion portion of this lesson, we discussed the entries that are made on the DA Form 3444-Series and DA Form 8005-Series terminal digit file folders. During this practical exercise session, you will get the opportunity to actually complete several simulated file folders for fictitious patients.

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records. As you will discover, medical records may by the very basis for continued good treatment of patients.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork’s done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown

together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 01: MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
Photocopies of the front of a DA Form 3444-Series or DA Form 8005-Series; four (4) per student.

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:

You may consider that it is the year 1995 and that you are assigned to a Medical Records Branch, Patient Administration Division. Your duties require you to prepare, maintain, retrieve, and file terminal digit file folders for patients.

EXERCISE:

Using photocopies of terminal digit file folders, fill in the blocks and blanks for the terminal digit file folders and write the color for the folder across the front of the sheet for each of the patients' data below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the folder copies, turn them in to the instructor.

PATIENT DATA:

Bebak, Francis J., PV2, social security number 656-12-4454, blood type AB-. has been admitted to your facility for treatment for gastroenteritis.

Price, James A. is the first-born child of active duty CPT. John J. Price.

CPT Price's SSN is 611-11-0305, Mrs. Price's SSN is 764-47-7305, and little James' SSN is 611-44-1289. Mrs. Price has brought James into your facility for outpatient treatment where he has no treatment folder.

Joe, George I., SSG, SSN 224-56-8294, Company A, 2nd BN, AHS requires treatment for a sprained ankle and his health record has been destroyed during a PCS move. His blood type is O+.

Marsh, George M., retired Army Major, Army service number 093-21-4788, SSN 437-89-0001, blood type AB+, is brought into your facility with a possible heart attack. He has no records on file. His wife is an active duty Marine Brigadier General, SSN 650-00-7853 with 27 years service.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

SITUATION:

You may consider that it is the year 1995 and that you are assigned to a Medical Records Branch, Patient Administration Division. Your duties require you to prepare, maintain, retrieve, and file terminal digit file folders for patients.

EXERCISE:

Using photocopies of terminal digit file folders, fill in the blocks and blanks for the terminal digit file folders and write the color for the folder across the front of the sheet for each of the patients' data below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the folder copies, turn them in to the instructor.

PATIENT DATA:

Bebak, Francis J., PV2, social security number 656-12-4454, blood type AB-. has been admitted to your facility for treatment for gastroenteritis.

Price, James A. is the first-born child of active duty CPT. John J. Price. CPT Price's SSN is 611-11-0305, Mrs. Price's SSN is 764-47-7305, and little James' SSN is 611-44-1289. Mrs. Price has brought James into your facility for outpatient treatment where he has no treatment folder.

Joe, George I., SSG, SSN 224-56-8294, Company A, 2nd BN, AHS requires treatment for a sprained ankle and his health record has been destroyed during a PCS move. His blood type is O+.

Marsh, George M., retired Army Major, Army service number 093-21-4788, SSN 437-89-0001, blood type AB+, is brought into your facility with a possible heart attack. He has no records on file. His wife is an active duty Marine Brigadier General, SSN 650-00-7853 with 27 years service.

PRACTICAL EXERCISE SHEET PE HPABG022 02

Title

Medical Records I - Temporary Medical Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Manila Folders, 9"x12', one (1) per student in the class.
DA Form 2005. with signature blanks completed, one (1) per student in the class.

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1997, you are a part of a deployed Patient Administration Division working out of tent facilities. You have several patients checking in for care, but you have none of their records.

EXERCISE:
Prepare temporary medical records for each of the patients listed below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the records, turn them in to the instructor.

PATIENTS:
Grayson, Richard R., SSGT, SSN: 222-55-8987 has come into the MTF because he caught his hand a door.
Peterson, Marilyn P., PVT, SSN 493-76-8462 wishes to be treated for a cold.
Macson, Mason M., Jr., Major, US Army, Retired, SSN 745-99-9988, son of Macson, Mason M., Sr., General, US Army, SSN 238-47-2395 is working as a civilian technical advisor to Army on a missile project is seeking treatment for a pain in his chest.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

SITUATION:
In the year 1997, you are a part of a deployed Patient Administration Division working out of tent facilities. You have several patients checking in for care, but you have none of their records.

EXERCISE:
Prepare temporary medical records for each of the patients listed below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the records, turn them in to the instructor.

PATIENTS:
Grayson, Richard R., SSGT, SSN: 222-55-8987 has come into the MTF because he caught his hand a door.
Peterson, Marilyn P., PVT, SSN 493-76-8462 wishes to be treated for a cold.
Macson, Mason M., Jr., Major, US Army, Retired, SSN 745-99-9988, son of Macson, Mason M., Sr., General, US Army, SSN 238-47-2395 is working as a civilian technical advisor to Army on a missile project is seeking treatment for a pain in his chest.

PRACTICAL EXERCISE SHEET PE HPABG022 03

Title

Medical Records I - Ambulatory Procedure Visit Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-

Student Materials:
Student handout "Medical Records I Student Handout" , M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1999, you are a part of an Ambulatory Procedure Unit associated with an MTF. Assume that your unit has patients requiring immediate (day of procedure), preprocedure, and immediate post procedure care.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

SITUATION:
In the year 1999, you are a part of an Ambulatory Procedure Unit associated with an MTF. Assume that your unit has patients requiring immediate (day of procedure), preprocedure, and immediate post procedure care.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

PRACTICAL EXERCISE SHEET PE HPABG022 04

Title

Medical Records I - Observation Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1999, you are a part of a Patient Administration Branch associated with an MTF. Assume that your unit has outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition, therefore they are being placed in observation status.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 4

SITUATION:
In the year 1999, you are a part of a Patient Administration Branch associated with an MTF. Assume that your unit has outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition, therefore they are being placed in observation status.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG023
TSP Title	Medical Records II
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP Contains

TABLE OF CONTENTS

HPABG023 version 1 / Medical Records II
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0203	Prepare an Observation Record
081-866-0204	File Authorized Forms in a Health Record (HREC)
081-866-0205	File Authorized Forms in an Outpatient Treatment Record (OTR)
081-866-0206	File Authorized Forms in an Inpatient Treatment Record (ITR)
081-866-0207	File Authorized Forms in an Ambulatory Procedure Visit (APV) Record.

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	4.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	4.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
MCHO-CL-P (40)	MEDCOM Memorandum	16 Oct 1997	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
DA Form 8005	Outpatient Medical Record (OMR) Orange	01 Jan 1900	
DA Form 3444-Series	Terminal Digit File for Treatment Record	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:
Pointer
35mm slide projector, hand control, and screen
Slides S HPABG023 01-22

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Classroom, Training Area, and Range Requirements

CLASSROOM LABORATORY EQUIPPED 44PER

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

The Instructor should distribute student handouts prior to the start of classroom presentation.

Proponent Lesson Plan Approvals	**Name**	**Rank**	**Position**	**Date**

SECTION II. INTRODUCTION

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 4 hrs
Media: PRINT

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Slide S HPABG023 01: Medical Records II

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	File authorized forms in a Health Record (HREC).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must file authorized forms in a HREC IAW AR 40-66.

1. Learning Step / Activity 1. Filing forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 02: Medical Records II: Filing Forms

a. Forms will be filed from top to bottom in a prescribed order, to make access easier,.
b. Copies of identical forms are to be grouped and filed in reverse chronological order with the most recent form on the top.
c. National Guard (NG) and US Army Reserve (USAR) members on active duty training will be marked "ADT" on the front of the file folder and on the lower margin each form filed within the folder.

Slide S HPABG023 03: Medical Records II: Filing Forms

NOTE: Folders for NG and USAR members will be maintained in the same manner as those for other active duty members.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Forms to be filed on the left side of the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

NOTE: (*)Entries indicate forms that will be prepared when a HREC is initiated.

Slide S HPABG023 03A: Medical Records II: Filing Forms

a. DA Forms 3180, 3180A: Personnel Screening and Evaluation Record (if applicable).
*b. DA Form 5571: Master Problem List.
*c. SF 601: Immunization Record.
*d. SF 545: Laboratory Report Display.
*e. SF 519 & 519A: Radiographic Report.

Slide S HPABG023 03B: Medical Records II: Filing Forms

f. DA Form 3647-1: Inpatient Treatment Record Coversheet copy.

g. SF 502: Narrative Summary copy.

NOTE: The following form is preprinted in the terminal digit file folders.

h. DA Form 4410-R: Disclosure Accounting Record.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Forms to be filed on the right side of the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

NOTE: (*)Entries indicate forms that will be prepared when a HREC is initiated.

Slide S HPABG023 03C: Medical Records II: Filing Forms

a. DA Form 4515: Personnel Reliability Program Record Identifier (if applicable).
*b. SF 600: Chronological Record of Medical Care (key form used to record patient care).
*c. SF 558: Medical Record -Emergency Care and Treatment.
*d. DA Form 5181-R: Screening Note of Acute Medical Care (will be filed here if used in place of SF 600).

Slide S HPABG023 03D: Medical Records II: Filing Forms

e. State ambulance forms: used to record ambulance (pre-hospital) treatment.
f. DA Form 3349: Physical Profile.
g. DA Form 3947: Medical Evaluation Board Proceedings.
*h. SF 88: Report of Medical Examination (original).

Slide S HPABG023 03E: Medical Records II: Filing Forms

*i. SF 93: Report of Medical History (original).
j. SF 513: Medical Record--(consultation sheet).
k. Living Will: an administrative document that may be filed in the HREC.

Slide S HPABG023 03F: Medical Records II: Filing Forms

NOTE: The following form is pre-printed in the terminal digit file folders.

*l. DD Form 2005: Privacy Act Statement (signed by the patient).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	File authorized forms in an Outpatient Treatment Record (OTR).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must file authorized forms in an OTR IAW AR 40-66.

1. Learning Step / Activity 1. Determine if the form is authorized.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 04: Medical Records II: Authorized Forms

a. Check the form title and reference number.
b. Refer to AR 40-66 and compare the form title and number to the list of authorized forms.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the form in the proper location in the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 05: Medical Records II: Forms Location

a. Check the patient identifier fields of the form for complete and correct information against the labeling on the folder.
b. Determine in which section of the folder to file the form.
(1) Check the form name and reference number.
(2) Refer to the AR 40-66 for the location in which to file the form.
(3) File the form in the proper location.

Slide S HPABG023 06: Medical Records II: Forms Location

NOTE: Forms should be filed in a location as specified in the AR 40-66. If forms are of the same form type (not copies), they should be filed chronologically with the most recent dated one on top.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	File authorized forms in an Inpatient Treatment Record (ITR).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 3444-Series Folder.
STANDARDS:	The soldier must file authorized forms in an ITR IAW AR 40-66.

1. Learning Step / Activity 1. Determine if the form is authorized.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 07: Medical Records II: Authorized Forms

a. Check the form title and reference number.
b. Refer to AR 40-66 and compare the form title and number to the list of authorized forms.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the form in the proper location in the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 08: Medical Records II: Forms Location

a. Check the patient identifier fields of the form for complete and correct information against the labeling on the folder.
b. Determine in which section of the folder to file the form.
(1) Check the form name and reference number.
(2) Refer to the AR 40-66 for the location in which to file the form.
(3) File the form in the proper location.

Slide S HPABG023 09: Medical Records II: Forms Location

NOTE: Forms should be filed in a location as specified in the AR 40-66. If forms are of the same form type (not copies), they should be filed chronologically with the most recent dated one on top.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	File authorized forms in an Ambulatory Procedure Visit (APV) record.

CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 3444-Series Folder
STANDARDS:	The soldier must file authorized forms in an APV record IAW AR 40-66.

1. Learning Step / Activity 1. Determine the appropriate forms to be filed in the APV record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 10: Medical Records II: APV

NOTE: The APV Record will not be Carded For Record Only. All documentation will be filed in a properly prepared DA 3444 series folder.

Slide S HPABG023 11: Medical Records II: APV

a. Determine the forms tile and reference number.
b. Determine if the forms are authorized for filing in an APV Record, in accordance with MEDCOM memorandum, MCHO-CL-C: Ambulatory Procedure Visit (APV), para. 5-g-(a).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the authorized forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 12: Medical Records II: APV

a. Forward a copy of the patient's post-procedure instructions, with a summary of care, e.g., SF 509 or SF 539, etc. to the health/outpatient treatment record.

NOTE: A control procedure should be initiated to ensure that the APV is annotated on the Master Problem List (DA Form 5571).

Slide S HPABG023 13: Medical Records II: APV

NOTE: An internal procedure for tracking the APV is to be developed by the MTF.

Slide S HPABG023 14: Medical Records II: APV

b. File all documentation related to the APV in a DA Form 3444-series folder or DA Form 8005-series folder, on the left side of the inpatient folder.

c. Store APV records in a limited access area of the MTF.

Slide S HPABG023 15: Medical Records II: APV

NOTE: Do not integrate the original APV record into the health/outpatient treatment record.

Slide S HPABG023 16: Medical Records II: APV

NOTE: APV records may be retired to the National Personnel Records Center IAW AR 25-400-2 five (5) years after the end of the year of the last inpatient disposition or APV. Army MEDDACs retire records 1 year after the end of the year of the last inpatient disposition or APV.

Slide S HPABG023 17: Medical Records II: APV

d. Forward a copy of the patient's post-procedure instructions, with a summary of care, e.g., SF 509 or SF 539, etc. to the health/outpatient treatment record.

Slide S HPABG023 18: Medical Records II: APV

NOTE: A control procedure should be initiated to ensure that the APV is annotated on the Master Problem List (DA Form 5571).

Slide S HPABG023 19: Medical Records II: APV

e. File all documentation related to the APV in a DA Form 3444-series folder or DA Form 8005-series folder, on the left side of the inpatient folder.

Slide S HPABG023 20: Medical Records II: APV

NOTE: An internal procedure for tracking the APV is to be developed by the MTF.

g. Store APV records in a limited access area of the MTF.

Slide S HPABG023 21: Medical Records II: APV

NOTE: Do not integrate the original APV record into the health/outpatient treatment record.

Slide S HPABG023 22: Medical Records II: APV

NOTE: APV records may be retired to the National Personnel Records Center IAW AR 25-400-2 five (5) years after the end of the year of the last inpatient disposition or APV. Army MEDDACs retire records 1 year after the end of the year of the last inpatient disposition or APV.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson we discussed some of the important aspects maintaining medical records. Various types of records were addressed, and the importance of proper record arrangement was emphasized. How and where to file forms and documents for the different types of records was discussed.

Check on Learning

Conduct a check on learning and summarize the lesson.

QUESTION: How are forms of the same type filed in the medical record?
ANSWER: On the designated side, in the proper location, and chronologically.

QUESTION: Are forms filed top to bottom or bottom to top?
ANSWER: Top to bottom.

QUESTION: What is the primary reference for filing medical record forms?
ANSWER: Medical Record Administration (AR 40-66)

QUESTION: In what type of a record is the APV filed?

ANSWER: Inpatient Treatment Record.

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records II" and "Medical Records Management". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PRACTICAL EXERCISE SHEET PE HPABG023 01

Title

Medical Records II: File Forms in a Health Record (HREC).

Lesson Number/Title

HPABG023 version 1 / Medical Records II

Introduction

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout" , M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in a Health Record, DA Form 3444-Series. Using the letter L to indicate left side of the record and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 601, Immunization Record.

2. _____ DA Form 3947, Medical Evaluation Board Proceedings.

3. _____ DA Form 2631-R, Medical Care--Third Party Liability Notification.

4. _____ SF 600, Chronological Record of Medical Care.

5. _____ DD Form 2005, Privacy Act Statement.

6. _____ DA Form 3349, Physical Profile.

7. _____ SF 88, Report of Medical Examination.

8. _____ SF 93, Report of Medical History.

9. _____ SF 560, Medical Record; Electroencephalogram Request and History.

10. _____ DA Form 4515, Personnel Reliability Program Identifier.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

Below is a list of forms that are normally filed in a Health Record, DA Form 3444-Series. Using the letter L to indicate left side of the record and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 601, Immunization Record.

2. _____ DA Form 3947, Medical Evaluation Board Proceedings.

3. _____ DA Form 2631-R, Medical Care--Third Party Liability Notification.

4. _____ SF 600, Chronological Record of Medical Care.

5. _____ DD Form 2005, Privacy Act Statement.

6. _____ DA Form 3349, Physical Profile.

7. _____ SF 88, Report of Medical Examination.

8. _____ SF 93, Report of Medical History.

9. _____ SF 560, Medical Record; Electroencephalogram Request and History.

10. _____ DA Form 4515, Personnel Reliability Program Identifier.

PRACTICAL EXERCISE SHEET PE HPABG023 02

Title	Medical Records II: File Forms in an Outpatient Treatment Record (OTR).
Lesson Number/Title	HPABG023 version 1 / Medical Records II
Introduction	
Motivator	Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.
Terminal Learning Objective	**NOTE:** Inform the students of the following Terminal Learning Objective requirements. At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements	Local S.O.P.
Risk Assessment Level	Low
Environmental Considerations	N/A
Evaluation	
Instructional Lead-In	Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in an Outpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 560, Electroencephalogram Request and History.

2. _____ DA Form 3180-A, Personnel Screening and Evaluation Record.

3. _____ DA Form 5571, Master Problem List.

4. _____ SF 519, Radiographic Report Display.

5. _____ SF 545, Laboratory Report Display.

6. _____ DA Form 3365, Authorization Medical Warning Tag.

7. _____ SF 600, Chronological Record of Medical Care.

8. _____ DD Form 2005 Privacy Act Statement.

9. _____ SF 600 Chronological Record Medical Care.

10. _____ DD Form 4410-R, Disclosure Accounting Record.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

Below is a list of forms that are normally filed in an Outpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 560, Electroencephalogram Request and History.
2. _____ DA Form 3180-A, Personnel Screening and Evaluation Record.
3. _____ DA Form 5571, Master Problem List.
4. _____ SF 519, Radiographic Report Display.
5. _____ SF 545, Laboratory Report Display.
6. _____ DA Form 3365, Authorization Medical Warning Tag.
7. _____ SF 600, Chronological Record of Medical Care.
8. _____ DD Form 2005 Privacy Act Statement.
9. _____ SF 600 Chronological Record Medical Care.
10. _____ DD Form 4410-R, Disclosure Accounting Record.

PRACTICAL EXERCISE SHEET PE HPABG023 03

Title	Medical Records II: File Forms in an Inpatient Treatment Record (ITR).
Lesson Number/Title	HPABG023 version 1 / Medical Records II
Introduction	
Motivator	Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.
Terminal Learning Objective	**NOTE:** Inform the students of the following Terminal Learning Objective requirements. At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements	Local S.O.P.
Risk Assessment Level	Low
Environmental Considerations	N/A
Evaluation	
Instructional Lead-In	Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in a Inpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ DA Form 4515, Personnel Reliability Program Record Identifier.

2. _____ DA Form 5179, Medical Record--Preoperative/Postoperative Nursing Document.

3. _____ DA Form 3647-1, Inpatient Treatment Record Cover Sheet.

4. _____ DA Form 3888, Nursing Assessment and Care Plan.

5. _____ DA Form 3947, Medical Evaluation Board Proceedings.

6. _____ DA Form 2984, Very Seriously Ill/Seriously Ill/Special Category Patient Report.

7. _____ DA Form 2631-R, Medical Care-Third Party Liability Notification.

8. _____ Administrative documents and other correspondence.

9. _____ SF 506, Clinical Record--Physical Examination.

10. _____ SF 516, Medical Report--Operation Report.

Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

Below is a list of forms that are normally filed in a Inpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ DA Form 4515, Personnel Reliability Program Record Identifier.

2. _____ DA Form 5179, Medical Record--Preoperative/Postoperative Nursing Document.

3. _____ DA Form 3647-1, Inpatient Treatment Record Cover Sheet.

4. _____ DA Form 3888, Nursing Assessment and Care Plan.

5. _____ DA Form 3947, Medical Evaluation Board Proceedings.

6. _____ DA Form 2984, Very Seriously Ill/Seriously Ill/Special Category Patient Report.

7. _____ DA Form 2631-R, Medical Care-Third Party Liability Notification.

8. _____ Administrative documents and other correspondence.

9. _____ SF 506, Clinical Record--Physical Examination.

10. _____ SF 516, Medical Report--Operation Report.

2. *Medical Histories*

An important component of a patient's medical record is his or her medical history. An important of the reengineered Military Health System is a standardized data system used within each branch of the military and by all of the branches. To reach the goal of standardized data and information capture, maintenance, and management, all personnel recording medical histories will need to ask the same questions and record answers using standardized abbreviations and forms.

This section D.2. includes procedures, training materials, forms, and abbreviations developed by the Air Force for interviewing patients and recording their medical histories. Although the Air Force created the materials, they are easily converted to other branches of the armed forces.

Recording Medical Histories, An Overview

INTERVIEWING GOALS

A. History Taking

1. Reviewing the Basics
   - Review the patient's medical record prior to interviewing the patient. (Note: You should be doing this anyway as part of preventive services.)
   - Review factors in the history taking process

2. Setting
   - Insure patient comfort, and be sure the patient is seated at eye level with the interviewer.
   - The patient gets your FULL attention; avoid interruptions.
   - Protect the patient's privacy, safety, and modesty. This is a MUST.

3. Be a good communicator. Work on skills that show interest, attention, acceptance, and understanding such as:
   - Eye contact with the patient
   - Your posture
   - Gestures you make
   - The words you use
   - DO NOT express negative reactions to patient information

4. Questioning
   - Help guide the patient using:
     a. Facilitation ("Mm-hmm, Go on")
     b. Reflection (Repeating what the patient says encourages the patient go provide more detail.)
     c. Clarification ("Tell me what you meant by…")
   - Ask direct questions; go from general to specific questions
   - Develop the attributes of symptoms using the **O,P,Q,R,S,T** method
   - AVOID asking leading questions

5. Structure of the Interview
   - First conduct a step-by-step evaluation of why the patient is here.
   - Then explore the patient's concern(s).
   - The most common method is a chronological account of concerns, events, disease, etc.
   - LISTEN TO THE PATIENT!

6. Documenting
   - Problem Oriented (Short)
   - SOAPP Notes

   The SOAPP note is the standard format used to record patient progress notes in an outpatient setting. The acronym refers to:

   S = SUBJECTIVE
   O = OBJECTIVE
   A = ASSESSMENT

P = PLAN
P = PREVENTION
S = SUBJECTIVE

- This is basically what the patient tells you and is your primary area of concern when recording information for the provider.
- Subjective information includes (suggested structure):
    a. Patient Identification
    b. Chief Complaint (c/c)
    c. History of Present Illness (HPI) "OPQRST"
    d. Associated Symptoms
    e. Current Meds
    f. Allergies
    g. Pertinent Social History

B. SOAPP Notes

1. S=SUBJECTIVE
    - Patient Identification: Age, sex, race, occupation, status
      Example: 18 y/o WM ADAF Med tech
    - Chief Complaint: If possible, in patient's own words
      Example 1: presents with "I have a painful click in my knee."
      Example 2: presents with c/o L Knee pain x 3 days
    - History of Present Illness (HPI) - This is where we begin to develop the Symptom Attributes to fill in the details. A common method is using "**OPQRST**":

      O: Onset (When/How did it start?)
      P: Provocative/Palliative (What makes it better/worse?)
      Q: Quality (Sharp, dull, aching, throbbing?)
      R: Region/Radiation (Where is it, does it radiate?)
      S: Severity/Strength (Scale of 1-10? compared to? Any limitations?)
      T: Time/Treatment (Had before? When? Compare then and now? Duration? Treatment - if meds include exact dose/frequency, relief from treatment?)

    - While we realize that "OPQRST" may not exactly apply to every patient presentation, it is certainly a good starting point when beginning interviews.
    - HPI may also include pertinent questions about past medical history, immunizations, habits, hobbies, religious preference, living conditions, finances, exposures, family history, or other associated symptoms based on the suspected systems that are involved. This will become more familiar to you with extended experience.
    - Other appropriate questions for female patients with potential OB/GYN disorders:
        a. Gravida/Para?
        b. Last Normal Menstrual Period (LNMP)?
        c. Sexual Activity?
        d. Method of Birth Control (including problems i.e. missed pills)
        e. Current Medications (May already be noted in HPI); Include dosage/frequency/relief or effectiveness, and ask about preparations commonly not considered meds such as aspirin, vitamins, and birth control pills.
        f. Allergies: drugs, insects, food, other?

- Pertinent Social History - Remember the Stages of Change and appropriate intervention counseling techniques.
    a. *Tobacco* - (smoke, dip or chew) frequency/quantity?
    b. *Alcohol* – type/frequency/quantity?
    c. *Life style* - diet, exercise?

2. O = OBJECTIVE
    - This is what is observed in the patient by medical personnel and includes:
        a. Vital Signs
        b. General Impression
        c. Physical Exam
        d. Results of any same day procedures/lab tests
    - The majority of Objective information comes from the provider. However, you provide vital sign information and may be called upon to provide the general impression. Example: 28 y/o well developed, well nourished, black male, oriented and in no acute distress
    - Skilled Technician Support
        a. Knowing the involved systems (and your provider approach), you will be responsible to insure the patient is appropriately prepared for the physical exam and that all materials needed for the exam (instruments, supplies) are pre-positioned so as to expedite the process.
        b. Remember that at all times but especially at this point in the process, you must continuously keep the patient informed of any delays in seeing the provider. THIS IS AN EXTREMELY IMPORTANT COURTESY THAT MUST NOT BE OVERLOOKED!
        c. You will also assist the provider with the exam and any special procedures and will come to realize this can be a great learning experience.
        d. Again, clinicians will differ in their approach and some adaptation is expected, but you are now on your way to becoming a truly cohesive "Provider/Technician Team" that provides thorough, skillful care in a minimum amount of time.

3. A = ASSESSMENT

Based on the Subjective and Objective information, this is the provider's evaluation of what is going on with the patient. It may be a single diagnosis or a list of several probable diagnoses. As we mentioned earlier, if there is a list of probable diagnoses, then the Plan (P) will include further procedures or tests to help confirm or "rule out" some of the suspected causes of the patient's problem.

4. P = PLAN

This is the providers plan of care for the patient and generally includes:

- The actual treatment mechanism
- Meds (strength, dose, frequency, ROA, #given, refills)
- Therapy
- Crutches
- Other
- Further Testing (Lab, X-ray, ECG, etc.)
- Admin Support (Sick Slip, Profile, PRP recommendation)

- Patient Instructions (DOs/DON'Ts)
- Expectation of wellness
- Follow-up instructions

5. P = PREVENTION COUNSELING

This is done during every patient visit and is where we formally document advice given to the patient about high-risk behaviors identified during this visit and also for official referrals for further education from community based services. Example: HAWC. It is done in addition to addressing preventive health topics on DD Form 2766 as part of a PHA or HEAR evaluation. To assist you in performing this task (counseling), you will be given further training in counseling techniques for lifestyle risk factor reduction.

C. Verbal Communication With Providers

As a PCM technician, you will need to become very proficient at not only writing, but also speaking in terminology that communicates to your provider the patient's history. It is not necessary to read to the provider what you have written. You do, however, need to quickly give a synopsis of the pertinent positives and negatives from the interview.

This informal report must be organized in a format acceptable to your provider and must effectively relay the patient's presentation. Again, no two providers will want the same presentation and you will probably find that some variation is a beneficial learning experience.

You are not expected to be an expert immediately, as this skill takes time and experience to fully develop. With self-study and practice however, you will soon build a working relationship that runs like "clockwork".

D. Legal Considerations

To complete this lesson it is important that we discuss risk management considerations. Your behavior during the entire episode of care must remain above reproach. Specifically:

1. <u>During the interview</u>:

- DO NOT express negative reaction to any patient information
- Avoid appearing flippant, non-caring, or combative
- Avoid sexual banter, dirty jokes or crude language (unless this is the only thing the patient will understand)
- Ensure privacy and safety at all times

2. <u>During the Physical Exam</u> (with your provider):

- Keep the patient advised of any delays
- Ensure safety and privacy at all times
- Always chaperone when appropriate
- Explain what is being done and why, ensure the patient understands
- Give honest answers (to include "I don't know, but we'll find out") when the patient ask for information
- Know your job! Always demonstrate that you are a professional, and a key member of the healthcare team.

3. <u>In the Medical Record</u>:

You must be aware that anything written in the healthcare record has the potential to become legal evidence in a court of law.
Some Documentation Tips:

- Anytime you write in a medical record insure the complete patient ID information is on the form you are writing on (not writing in John Junior's record when your caring for John Senior)
- Write neatly and legibly in blue/black ink - A MUST!
- DO NOT write editorial comments or opinions; be like Joe Friday (Dragnet) "Just the Facts"
- DO NOT alter a medical record (even coffee stains). Errors are struck through with a single line, initialed and dated.
- Your provider should always document any follow-up instructions given to the patient.

E. Sample Technician Entry

S - 18 y/o WM, ADAF Amn, personnel tech, c/o "my L knee hurts" x 3 days. Playing basketball, jumped to shoot, upon landing twisted knee with immediate pain/swelling. Used ice/rest but continued pain, worse with activity (standing, marching, running), better with rest. Pain located laterally, throbbing, without radiation. No popping/locking but unstable with lateral movement. No Hx of knee injury, No significant PMH, NKDA. Meds - Advil 200mg, 2 tabs BID x 2 days with some relief. SH - denies tobacco or ETOH use

O - VS: BP 110/80 R12 P80 T97.6, Gen Imp: Well male in NAD, ambulates with limp

PLAN OF INSTRUCTION - LESSON PLAN (PART I)

COURSE TITLE	TIME
Aeromedical Apprentice (B3ABY4F0X1-001)	8 / 0

BLOCK TITLE	BLOCK NUMBER
Physical Exams	VII

UNIT TITLE	UNIT NUMBER
Recording a Medical History (SF 93)	12

STS REFERENCE	MEASUREMENT	PROFICIENCY CODE
13b, 13c(2)	2b	W / P

OBJECTIVE: Given a problem case scenario and an SF 93, elicit a complete medical history IAW AFI 48-133.

SAMPLES OF BEHAVIOR
1. Identify terms associated with eliciting a medical history.
2. Explain procedures for completing the SF 93.
3. Describe the technique and procedure for soliciting a medical history.
4. Describe the two types of medical histories.

SUPPORT MATERIAL AND GUIDANCE

STUDENT REFERENCES:
Aeromedical Apprentice Student Handout
AFP 48-133
AFI 48-123

TRAINING EQUIPMENT: Audiovisual Projection Unit

AUDIOVISUAL AIDS: Projection Media

TRAINING METHODS: Lecture (2 hours) and Demonstration / Performance (6 hours)

INSTRUCTOR GUIDANCE:
This unit of instruction will be divided into two sections. In Section One, the instructor will deliver a two-hour informal lecture utilizing various questioning techniques to foster student interaction in the lecture. Section Two will consist of 3-two hour lab rotations. The students will be given problem cases to work out. Try to have the students accomplish at least two problem cases per rotation. Review the problem cases and give the students ideas on how they can improve their medical histories. Following the lecture and the rotations, the students should have a very good understanding of the art of history taking.

INSTRUCTOR REFERENCES:
AFP 48-133
AFI 48-123

ADDITIONAL INSTRUCTOR REQUIREMENTS: None

PART II - TEACHING GUIDE

I. COURSE NUMBER AND TITLE: B3ABY4F031-001, Aeromedical Apprentice

II. SUBJECT: Physical Examination Techniques and Procedures

III. LESSON: Recording a Medical History

IV. TIME REQUIRED: 2 Hours

V. INSTRUCTOR:

VI. INTRODUCTION:

A. Attention:

B. Motivation:

Lesson Objective: Given a problem case scenario and an SF 93, elicit a complete medical history. IAW AFI 48-133.

D. Overview:

1. Identify terms associated with eliciting a medical history.
2. Explain procedures for completing the SF 93.
3. Describe the technique and procedure for soliciting a medical history.
4. Describe the two types of medical histories.

E. Transition:

VII. DEVELOPMENT:

A. Definitions:

1. **Childhood** - if an item of medical history occurred when the examinee was age 11 or younger, it occurred in childhood

2. **NCNS** - no complications, no sequela
   a. Complications - refers to a disease condition concurrent with another disease

   b. Sequela - a condition following or occurring as a result of another condition or event

3. **Complete medical history -** any medical history from childhood to present

   a. Must be accomplished for the following:

      1. Enlistment or Commission in the AF active duty or its Reserves

      2. On all ARC member physical exams IAW AFI 48-123

      3. Whenever the examining physician requests

b. Must be brought forward with each PHA or

1. Periodic flying and non-flying examinations

2. Whenever an examination is sent for higher authority review

4. **Interval medical history -** only significant items of medical history since the last examination are recorded and added to the end of the complete medical history

B. Completion of SF 93 by Examinee

1. Examinee **must** complete the SF 93 in one copy

2. Items 1 through 7 may be typewritten (same format as items on SF 88)

3. Item 8 (Must be in examinee's handwriting)

a. Short statement of examinee's present health

b. List any current medication

4. Items 9 and 10 - examinee will place an "X" in the appropriate yes or no block

5. Item 11 - examinee will place an "X" in the appropriate yes, no, or don't know block

6. Item 12 - for female examinee's only - male examinee's enter N/A

7. Item 13 - self explanatory (examinee's handwriting)

8. Item 14 - self explanatory (examinee's handwriting)

9. Item 15 - 24 (examinee's handwriting)

a. Must check appropriate block

b. Must explain affirmative checks in the blank space to the right of the questions preceded by the item reference number

10. Signature - have the examinee read the statement above the signature block, then print and sign their name

C. Soliciting and Writing a Medical History

1. Always done in a private place

2. Recorded first in a rough draft

3. Must have dates - final is in chronological order (childhood to present)

4. **ALL** affirmative and "don't know" check marks must be explained to the technician by the examinee

D. Writing the Medical History

1. **First step - Ask...**

    a. Did you have any *childhood diseases*?

    b. Did you have any *operations as a child*? If so, what were they for?

    c. Do you have any *scars* from injuries suffered in childhood that are one inch in length or longer?

2. **Second step - Review the SF 93...**

    a. *Item 8* - if health is less than good or on medications a comment must be made

    b. *Items 9 and 10* - record the necessary information for any item answered affirmatively (**except** for block 10, item 2)

    c. *Items 11 and 12* - record the necessary information for any item answered affirmatively (also includes "don't know responses)

    d. *Items 15 through 24* - elaborate further

3. **Third step - Ask...**

    a. Is there a history of *diabetes* in yourself or your family (parent, sibling, or more than one grandparent)?

    b. Is there a history of *psychosis* (mental illness) in yourself or in your family (parent or sibling)?

    c. Do you now or have you ever worn *contact lenses*?

    d. Have you ever had *irradiation therapy*?

    e. Have you ever experienced motion sickness or a *disturbance of consciousness*?

    f. Are there *any other items* of medical or surgical history that you have not mentioned?

E. Recording the Medical History

1. History is typed in item #25 on SF 93 in the following order:

    a. Common childhood diseases

    b. Operations in childhood

    c. Significant traumatic scars form childhood injuries

    d. Items from the SF 93 in chronological order

    e. List any affirmative answers from “third step”

(1) If all questions were negative responses, record the long denial statement

(2) If there are affirmative responses to any of the questions, omit the corresponding phrase from the denial statement

2. **LONG DENIAL STATEMENT** - Examinee denies personal or family history of diabetes or psychosis, use of contact lenses, history of motion sickness or disturbances of consciousness, irradiation therapy and all other significant medical or surgical history

F. Interval Medical History

1. Accomplished when a complete history is already on file

2. Significant items of medical history recorded

a. Required hospitalization

b. Required excusal, grounding, profile change or suspension from flying status

c. Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required, the illness is of a frequent or chronic nature, or it precluded flying

3. Obtaining information

a. Ask the examinee

b. Review the medical records

c. Use SF 93 as a guide

4. Record in chronological order - same way as complete medical history (diagnosis, date, cause, treatment, recovery, complications, sequela)

5. Recorded on most current SF 93 using the SF 507 when additional space is needed.

6. **SHORT DENIAL STATEMENT** - "No other significant medical or surgical history to report since last examination (enter the date of that examination in parentheses)

7. If no interval medical history replace the words "other significant" with "interval"

VIII. CONCLUSION:

A. Summary:

1. Definitions

    a. Childhood - age 11 or younger

    b. NCNS

    c. Interval medical history

    d. Complete medical history - when accomplished

2. Completion of SF 93 by examinee

3. Soliciting and writing a medical history

4. Procedures for writing a medical history

5. Recording the complete medical history

6. Recording the interval medical history

B. Remotivation:

C. Closure:

OBTAIN AND RECORD MEDICAL HISTORY

SUBJECT AREA: Nursing Care in the Outpatient Clinic

TASK NAMES: History and physical; Obtain and record medical histories

EQUIPMENT REQUIRED:

1. SF 600, blue/black ink pen and patient scenario
2. References as determined necessary by the individual being evaluated

TRAINING REFERENCES: Guide to Physical Examination

OBJECTIVE: Provided a patient, medical records, and clinical setting, obtain and record the problem-oriented history (S portion of the SOAPP note) using the SOAPP format

EVALUATION INSTRUCTIONS:
Insure the trainee has completed the read-ahead module (attachment 5) prior to classroom lecture. Conduct lecture using lesson plan (attachment 2) and slide set (attachment 6).
After the trainee has received instruction allow sufficient practice on each part of the task.
Use the performance checklist (attachment 1) to ensure all steps of the task are accomplished. Trainees may role-play using locally developed or provided scenarios (attachment 3) and common terms (attachment 4).
Document task competency upon completion of the evaluation in the trainee's OJT record. Initial evaluation should be documented on the USAFE Command AF 797. All recurring evaluations should be documented on AF Form 1098.

NOTE: The evaluator will **STOP** the procedure immediately and correct the trainee if performance is detrimental to patient safety.

STEPS IN TASK PERFORMANCE:

1. Obtain patient history
2. Document history and physical in SOAPP format

ATTACHMENTS: 1. Performance checklist (QTP)
2. Lesson Plan
3. Patient History Scenarios
4. Common Terms
5. Read Ahead Module
6. Lesson Plan Slide Set

VOL 4 MODULE 2 OBTAIN AND RECORD MEDICAL HISTORY:
Attachment 1

PERFORMANCE ITEM	SAT	UNSAT
1. Obtain patient history a. Chief Complaint (uses patients own words) b. History of present illness 1. O: Onset P: Provocation/Palliation Q: Quality R: Radiation S: Severity T: Timing c. Associated symptoms		

PERFORMANCE ITEM	SAT	UNSAT
d. History and habits pertinent to the chief complaint 1. Allergies 2. Medications 3. Previous medical/surgical care 4. Habits: a. Diet b. Sleep c. Alcohol d. Caffeine e. Tobacco f. Substance e. Other problems 3. Document history in SOAPP format a. Subjective history must be in easily understood format and include all pertinent positives and negatives **CRITICAL CRITERIA** Failure to obtain ***Chief Complaint*** Failure to obtain ***OPQRST*** Failure to obtain patient ***Allergies*** Failure to document significant data in easily understood format		
FINAL RESULT:		